

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

ENTRANCE OF DEATH: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carefully. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03736 03736
CERTIFICATE OF DEATH
03733

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Medley's Neck				c. LENGTH OF STAY IN 1b 30 years			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS Rural Medley's Neck			
3. NAME OF DECEASED (Type or print) First Victor Middle H. Last Brubacher				4. DATE OF DEATH Month March Day 4 Year 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 25, 1895	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) Butterfield, Minnesota	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert H. Brubacher				14. MOTHER'S MAIDEN NAME Johanna Hubin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 217-32-2285		17. INFORMANT Sara Brubacher Address Same as # 2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Paralysis 356.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, } (b) Angiotrophic Lateral Sclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) none				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Hour none e.m. none p.m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/2/60 19 60 , to 3/4 19 62 , that (I) (we) last saw the deceased alive on 3/4 19 62 , and that death occurred at 7AM , from the causes and on the date stated above.							
22a. SIGNATURE Julian S. Lane M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/4/62	
22c. PHYSICIAN'S NAME (Type) Julian S. Lane M. D.				22d. ADDRESS Lexington Park, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 6, 1962		23c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery		23d. LOCATION (City, town or county) (State) Leonardtown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtown, Maryland			
25a. REC'D BY REGISTRAR W. Clarke Mattingley				25b. REGISTRAR'S SIGNATURE W. Clarke Mattingley			

W. Clinton Hastings, Jr., Secretary

5091 • J. Neurosci., July 26, 2006 • 26(30):5085–5091

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cases, papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03737

03737

CERTIFICATE OF DEATH

03734

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mechanicsville			
c. LENGTH OF STAY IN b 4 days				d. STREET ADDRESS St. Mary's Hospital			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Almon Middle Mason Last Clapp				4. DATE OF DEATH Month March Day 3 Year 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 8, 1886	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 75 Days 0 Hours 0 Min. 0		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Training Officer V. A. Civil Service				10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C.			
13. FATHER'S NAME William Ellis Clapp				14. MOTHER'S MAIDEN NAME Ella Hedrick			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes				16. SOCIAL SECURITY NO. Mrs Ruth B. Clapp			
17. INFORMANT Mrs Ruth B. Clapp				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fast ventricular red thrombosis with hemorrhage DUE TO 159X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) 159X DUE TO (c) 159X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary metastasis, Arteriosclerosis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 3, 1961, to March 3, 1962, that (I) (we) last saw the deceased alive on March 3, 1962, and that death occurred at M, from the causes and on the date stated above.							
22a. SIGNATURE J. Roy Guyther M. D.				22b. DATE SIGNED 3/5/62			
22c. PHYSICIAN'S NAME (Type) J. Roy Guyther M. D.				22d. ADDRESS Mechanicsville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF March 6, 1962			
23c. NAME OF CEMETERY OR CREMATORY All Faith Cemetery				23d. LOCATION (City, town or county) (State) Charlotte Hall, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				25a. REC'D BY REGISTRAR 6/62			
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03738

03735

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtown c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Leonardtown d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle F. Last Hebb		4. DATE OF DEATH Month March Day 22 , Year 19 62	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1879
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 2 Days 22	IF UNDER 24 HRS. Hours 22 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Hanson Hebb		14. MOTHER'S MAIDEN NAME Lillian Ann Perpha	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 215 32 4451	
17. INFORMANT Joseph H. Hebb		Address 1342 N. Fremount Ave Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure - Pneumonia DUE TO (b) Hemiplegia DUE TO (c) Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 15, 1957 to March 22, 1962, that (I) (we) last saw the deceased alive on March 22, 1962, and that death occurred at 3 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Charles Greenwell M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE 3/22/62
22c. PHYSICIAN'S NAME (Type) Charles Greenwell M.D.		22d. ADDRESS Leonardtown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/26/62	23c. NAME OF CEMETERY OR CREMATORY Our Lady's Chapel	23d. LOCATION (City, town or county) (State) Medley's Neck, Md.
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown, Md.	
25a. REC'D BY REGISTRAR W. Clarke Mattingley		25b. REGISTRAR'S SIGNATURE W. Clarke Mattingley	
DATE MAR 27 '62			

(M)

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Department of the Interior, Bureau of Land Management, Washington, D.C.

George F. Hobb, March 22, 1978

John H. Hobb, June 19, 1978

John H. Hobb, March 22, 1978

John H. Hobb, March 22, 1978

John H. Hobb, March 22, 1978

John H. Hobb, March 22, 1978

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03736

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural A bell c. LENGTH OF STAY IN 1b 3 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Abell d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Julia Ann Hill		4. DATE OF DEATH Month March Day 20 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1875
9. AGE (In years last birthday) 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Henry Goode		14. MOTHER'S MAIDEN NAME Turner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Helen Pingleton Abell, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1 19 57 to March 20 19 62 , that (I) (we) last saw the deceased alive on March 19 19 62 , and that death occurred at 2 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Charles Greenwell M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Charles Greenwell M. D.		22d. ADDRESS Leonardtown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/22/62	
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		23d. LOCATION (City, town or county) (State) Bushwood, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		25a. REC'D BY REGISTRAR Leonardtown	
ADDRESS Leonardtown, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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UNITED STATES OF AMERICA

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03740

CERTIFICATE OF DEATH

03737

Items 8 & 9 Film G310 1/2/62 mh

1. PLACE OF DEATH

a. COUNTY

St. Mary's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Leonardtwn

c. LENGTH OF STAY IN 1b

4 1/2 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

St. Mary's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Rural Leonardtown,

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?
YES ☒ NO ☐

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Annie

Elizabeth

Latham

4. DATE OF DEATH

Month

Day

Year

March

16,

1962

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

1877

9. AGE (In years last birthday)

86 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John R. Knott

14. MOTHER'S MAIDEN NAME

Lottie Copsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Address

Ella R. Latham

Leonardtwn, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4-20-01 DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

DUE TO

(c)

Congestive Heart Failure
Coronary Artery Disease
Atherosclerosis

INTERVAL BETWEEN ONSET AND DEATH

5 yrs.

10 yr

15 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour e.m.
p.m.

Month, Day, Year

19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Oct 1957 to Mar 1962; that (I) (we) last saw the deceased alive on 19 and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

David L. Mossman M. D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22d. ADDRESS

Mechanicsville, Maryland

22b. DATE SIGNED

3/19/62

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

March 19, 1962

23c. NAME OF CEMETERY OR CREMATORY

Our Lady's Chapel

23d. LOCATION (City, town or county)

Medley's Neck,

Md.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

W. Clarke Mattingley Leonardtown, Maryland

25a. REC'D BY REGISTRAR

MAR 22 '62

25b. REGISTRAR'S SIGNATURE

Arthur L. House

6430

M

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TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03741

CERTIFICATE OF DEATH

Reg. Dist. No. 03738

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. LENGTH OF STAY IN 1b <u>5 minutes</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u>	
		d. STREET ADDRESS <u>75 East Rennell Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>Lee</u> Anne Last <u>Lester</u>		4. DATE OF DEATH Month <u>3</u> -Day <u>2</u> -Year <u>62</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-2-62</u>
9. AGE (In years last birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>David Merrill Lester</u>		14. MOTHER'S MAIDEN NAME <u>Janet Lee Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mother</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prerenatality</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prerenatality</u> DUE TO (c) <u>Prerenatality</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/2</u> 19 <u>62</u> , to <u>3/2</u> 19 <u>62</u> , that I last saw the deceased alive on <u>3/2</u> 19 <u>62</u> , and that death occurred at <u>9:45</u> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>5/3/62</u>	
ACTUAL SIGNATURE <u>Dr. James P. Jarboe</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Dr. James P. Jarboe</u>		<u>Great Mills, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL, (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3-5-62</u>	<u>St. Aloysius</u>	<u>Leonardtown, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingly</u>		ADDRESS <u>Leonardtown, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 6 '62</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. G. G. G.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03742

CERTIFICATE OF DEATH

03759

Item 8 Film G310 4/2/62 m

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown c. LENGTH OF STAY IN 1b 12 hrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Mary's Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Maddox d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) William Alexander Lyon First Middle Last		4. DATE OF DEATH March 22, 1962 Month Day Year	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1876 9. AGE (In years last birthday) 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Charles County, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. Lyon		14. MOTHER'S MAIDEN NAME Julia Freeman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. Michael Wolfe 17. INFORMANT Maddox, Maryland Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) + 22.1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) POTTS DISEASE - MANY YEARS DURATION		INTERVAL BETWEEN ONSET AND DEATH 2 yrs + 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter no line of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1962 to Mar 22, 1962 , that (I) (we) last saw the deceased alive on 3/20/62 19 and that death occurred at 11 M, from the causes and on the date stated above.			
22a. SIGNATURE J. Roy Guyther 22c. PHYSICIAN'S NAME (Type) J. Roy Guyther M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Mechanicsville, Maryland	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 3/24/62	
23c. NAME OF CEMETERY OR CREMATORY Dentsville, Md.		23d. LOCATION (City, town or county) (State) Dentsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley ADDRESS Leonardtown, Md.		25a. REC'D BY REGISTRAR MAR 27 '62 DATE 25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

03743

CERTIFICATE OF DEATH

Reg. Dist. No. 03740

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown				c. LENGTH OF STAY IN 1b 39 minutes			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Norris				4. DATE OF DEATH Month Day Year 3-2-62 19			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-2-62		9. AGE (In years last birthday) yrs	10. IF UNDER 1 YEAR Months Days Hours Min. 39	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Joseph Aloysius Norris				14. MOTHER'S MAIDEN NAME Dorothy Ann Blackiston			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO no			
17. INFORMANT Mother				Address above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 776X DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3/2 , 19 62 to 3/2 , 19 62 that I last saw the deceased alive on 3/2 , 19 62 , and that death occurred at 8:45 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Great Mills, Md. DATE SIGNED 3/3/62							
ACTUAL SIGNATURE Dr. James P. Jarboe				PHYSICIAN'S NAME (Type) Dr. James P. Jarboe			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial				22b. DATE THEREOF 3-5-62		22c. NAME OF CEMETERY OR CREMATORY St John's	
22d. LOCATION (City, town, or county) (State) Hollywood Md							
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingly				ADDRESS Leonardtown, Md		24a. REC'D BY REGISTRAR DATE MAR 8 '62	
24b. REGISTRAR'S SIGNATURE C. A. ...							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO MARRIED PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 1, 2, and 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

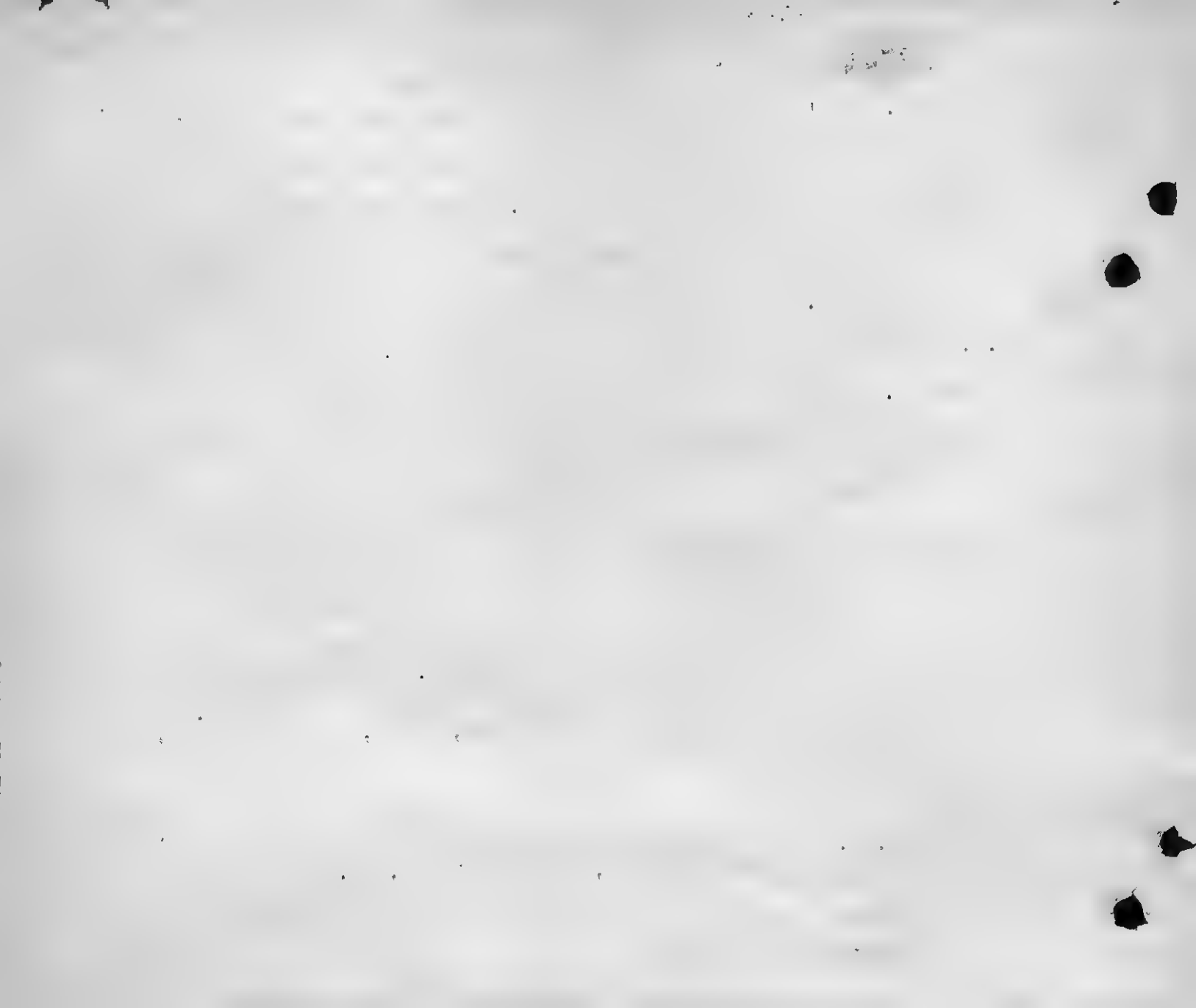
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03744

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03741

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland Ohio b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Station Hospital, USNAS		d. STREET ADDRESS U.S. Naval Air Station	
3. NAME OF DECEASED (Type or print) Thomas Michael OAKLEY	First Middle Last	4. DATE OF DEATH March 7 1962	Month Day Year
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 19 1943
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY		9b. AGE (In years last birthday) 18 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) GREENVILLE, OHIO		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Marvin C. OAKLEY		14. MOTHER'S MAIDEN NAME Martha SCHOOLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes 15 Sep 61 to 7 MAR 62		16. SOCIAL SECURITY NO. 271 387 716	
17. INFORMANT OFFICIAL NAVAL RECORDS		Address	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage secondary to Laceration Liver			
936.8 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. Crushed between two hangar doors at Hangar 109			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I. or Part II. of item 18.)			
20c. TIME OF INJURY Month, Day, Year 1:42 p.m. MARCH 7 1962			
20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hangar 109, USNAS, Patuxent River, Maryland			
20f. (City or town) (County) (State) St. Mary's			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/> W. R. Swan M.D. DATE SIGNED March 1962			
ASS. STANT MEDICAL EXAMINER <input type="checkbox"/> William D. Boyd			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Leonardtown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit & Burial 3/9/62			
22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY P.B. Robinson - Leonardtown, Md.			
22d. LOCATION (City, town, or country) (State) Greenville, Ohio			
24a. REC'D BY REGISTRAR MAR 12 '62			
24b. REGISTRAR'S SIGNATURE Arthur S. Thoma			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carefully. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03745

CERTIFICATE OF DEATH

03742

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chaptico</u> c. LENGTH OF STAY IN <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Life</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chaptico</u> d. STREET ADDRESS <u>Chaptico</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary</u> <u>Garner</u> <u>Reeves</u>		4. DATE OF DEATH Month Day Year <u>March</u> <u>10</u> , <u>1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 16, 1881</u>	
9. AGE (In years, last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours M.in.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Chaptico, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George R. Garner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr S. Sprigg Reeves Jr. Leonardtown, Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure - aortic stenosis</u> <u>422</u> DUE TO <u>ASCD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Interval between onset and death</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... <u>1957</u> to... <u>Mar 10</u> , 1962, that (I) (we) last saw the deceased alive on... <u>Feb 1</u> , 1962, and that death occurred at... <u>10</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Roy Guyther</u>		22b. DATE SIGNED <u>Mar 10</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Roy Guyther M. D.</u>		22d. ADDRESS <u>Mechanicsville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 12, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Chaptico, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
24a. ADDRESS <u>Leonardtown, Maryland</u>		24c. DATE <u>MAR 19 62</u>	

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FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 in the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03746

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03743

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Compton c. LENGTH OF STAY IN b 30 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if no in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Compton d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) John I. Stewart		4. DATE OF DEATH March 31 1962	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1891	
9. AGE In years (last birthday) 70		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (State or foreign country) Hollywood, Maryland		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME ?		15. MOTHER'S MAIDEN NAME ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes WW I		17. SOCIAL SECURITY NO	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (b) Caronary Infarct (c), stating the underlying cause last. Immed. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William D. Boyd M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William D. Boyd M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/5/62	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Arlington, Va.	
23. FUNERAL DIRECTOR W. Clarke Mattingley		24a. REC'D BY REGISTRAR Leonardtwn, Md.	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline		DATE APR 9 '62	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03748

03745

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b X Ridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last INFANT BOY GARY WAGGONER		4. DATE OF DEATH Month Day Year March 21 20 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1962
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		9b. KIND OF BUSINESS OR INDUSTRY -----	
10a. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY USA	
12. FATHER'S NAME Thomas J. Waggoner		13. MOTHER'S MAIDEN NAME Mary V. Roach	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		15. SOCIAL SECURITY NO. -----	
16. INFORMANT Thomas J. Waggoner - Ridge, Maryland		Address -----	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prob. intra cranial hemorrhage DUE TO Immature birth - breech presentation Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----		INTERVAL BETWEEN ONSET AND DEATH -----	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 3/20/62 19 to 3/21/62 19 that (I) (we) last saw the deceased alive on 3/20 19 and that death occurred at 4 A.M. from the causes and on the date stated above			
22a. SIGNATURE J. Roy Guyther		22b. DATE SIGNED 3/21/62	
22c. PHYSICIAN'S NAME (Type) J. Roy Guyther, MD		22d. ADDRESS Mechanicsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/22/62	
23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		23d. LOCATION (City, town, or county) (State) Ridge, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		25a. REC'D BY REGISTRAR DATE MAR 27 '62	
25b. REGISTRAR'S SIGNATURE Charles E. Thoma			

2-055323

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03749 CERTIFICATE OF DEATH 03746

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY in 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Mary's Hospital		d. STREET ADDRESS Box 144	
3. NAME OF DECEASED (Type or print) Joseph E. Woodland		4. DATE OF DEATH Month March Day 11 Year 1962	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1910
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 51 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Civil Service	
11. BIRTHPLACE Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Woodland		14. MOTHER'S MAIDEN NAME Mary Dorsey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 202-628-2709	
17. INFORMANT Alice M. Woodland		Address Box 144, Hughesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (b) 3 days (a), stating the underlying cause last. (c) 3 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive CV disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mar 9		20f. (City or town) (County) (State) Mar 11, 1962	
21. I certify that (I) (this hospital) attended the deceased from Mar 9, 1962 to Mar 11, 1962 , that (I) (we) last saw the deceased alive on Mar 11, 1962 , and that death occurred at 8:18 P.M. from the causes and on the date stated above.		22a. SIGNATURE J. Roy Gwyther	
22c. PHYSICIAN'S NAME (Type) J. Roy Gwyther		22b. DATE SIGNED Mar 11, 1962	
22d. ADDRESS Mechanicsville, Maryland		22e. REC'D BY REGISTRAR Arthur S. Kline	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-14-62	
23c. NAME OF CEMETERY OR CREMATORY St Marys		23d. LOCATION (City, town or county) (State) Bryantown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland		25a. REC'D BY REGISTRAR DATE MAR 15 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		25c. REGISTRAR'S SIGNATURE Arthur S. Kline	

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MINISTRY OF DEFENSE

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1. The purpose of this document is to provide information regarding the activities of the Ministry of Defense.

2. The Ministry of Defense is responsible for the defense of the country and the protection of its interests.

3. The Ministry of Defense is also responsible for the development and maintenance of the armed forces.

4. The Ministry of Defense is also responsible for the coordination of military operations.

5. The Ministry of Defense is also responsible for the provision of military equipment and supplies.

6. The Ministry of Defense is also responsible for the training of military personnel.

7. The Ministry of Defense is also responsible for the maintenance of military facilities.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03750

CERTIFICATE OF DEATH

03747

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn				c. LENGTH OF STAY IN 1b 7 days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood					
f. STREET ADDRESS Box 140				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Louise Middle V Last Zafiros				4. DATE OF DEATH Month March Day 14 Year 19 62					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 8, 12, 1908			
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 3 Days 4		11. IF UNDER 24 HRS. Hours 8 Min. 14		12. CITIZEN OF WHAT COUNTRY? Washington, D. C.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator				10b. KIND OF BUSINESS OR INDUSTRY C & P Telephone					
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? Washington, D. C.					
13. FATHER'S NAME Charles Alexandra				14. MOTHER'S MAIDEN NAME Nora ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 577-05-0532				16. SOCIAL SECURITY NO. Alexandrea J. Zafiros					
17. INFORMANT Hollywood, Maryland				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 434.3 DUE TO Pericarditis Conditions, if any, which gave rise to immediate cause (b) Viral pneumonia (c) chronic alcoholism PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic alcoholism								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 e.m. p.m.		Month, Day, Year 19 62		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from 3:30 to 3:14 , 19 62 that (I) (we) last saw the deceased alive on 3:40 , 19 62 , and that death occurred at 8:30 AM, from the causes and on the date stated above.									
22a. SIGNATURE Michael Barbarich M. D.				22b. DATE SIGNED March 19 62					
22c. PHYSICIAN'S NAME (Type) Michael Barbarich M. D.				22d. ADDRESS 329 Great Mills Rd. Lexington Park, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 17, 1962		23c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		23d. LOCATION (City, town or county) (State) 1801 E. Street S.E. Wash. D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland				25a. REC'D BY REGISTRAR Mar 19 62					
25b. REGISTRAR'S SIGNATURE Charles S. House				DATE MAR 19 62					

03750

(M)

State Building, Louisville, Kentucky

Unit I

General Building, Louisville, Kentucky

General Building, Louisville, Kentucky

General Building, Louisville, Kentucky

General Building, Louisville, Kentucky

General Building, Louisville, Kentucky

General Building, Louisville, Kentucky

General Building, Louisville, Kentucky

General Building, Louisville, Kentucky

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